

MARYLAND HEALTH CARE COMMISSION

UPDATE OF ACTIVITIES

May 2003

DATA SYSTEMS & ANALYSIS

Data Base and Application Development

Release of the 2002 Long-term Care Survey

MHCC will release the 2002 Long-Term Care Survey in August 2003. This survey collects information from about 700 long-term care facilities on facility characteristics, patient utilization, and sources of revenue. The survey will consist of approximately 75 questions, with most facilities answering fewer than 50 questions. The survey will be administered via the Internet as it has been for the past two years. Staff will offer training at several National Guard training centers around the state and at the DHMH Training Center on Preston Street. All of the training sites are equipped with large training rooms that contain Internet-enabled workstations.

In previous years, the Commission staff has released the survey in the fourth quarter of the year. The earlier release is in response to industry's request for rapid gathering of the data. Information from the survey is used in the Nursing Home Quality Reporting System and for a variety of health planning applications at the MHCC.

Ambulatory Surgery Survey

The Commission released the 2002 Ambulatory Surgical Center survey on March 28th to approximately 305 facilities. Over the last month, approximately 74 centers submitted their online survey responses. Since releasing the survey, MHCC has received about 10 telephone inquiries per day relating to completing the survey. Facilities have 60 days to complete the survey.

Internet-Based Re-Licensure Applications

Staff has completed modifications to the Board of Pharmacy's (BOP) Pharmacy Renewal application and has begun work on the BOP Pharmacist renewal. BOP will test these applications over the next several months and will release them for use in the late summer. MHCC staff will demonstrate the application to the BOP members at their August meeting.

MHCC staff has received a request for assistance from BPQA in modifying their physician renewal application to reflect the changes mandated by SB 500. That bill requires the BPQA, renamed to the Board of Physicians, to collect data on all malpractice judgments and data on malpractice settlements in the last 5 years with a monetary of \$150,000 from physicians that have 3 or more such settlements. The BPQA intends to collect this information through the renewal application beginning in 2003. Although all requested modifications had been previously completed, staff has agreed to assist the Board with additional modifications. Staff estimates that two weeks of one staff person's time will be needed to complete the modifications. BPQA intends to release this application about July 1st. Physicians have 90 days to complete the application.

Cost and Quality Analysis

Partnership with DHMH's Diabetes Prevention & Control Program (DPCP)

Staff met with Dr. John Ryan, Director of DHMH's Office of Disease Prevention, and Earl Schurman, who runs the DPCP, to discuss a study that would use MHCC's Medicare data to evaluate the effectiveness of DPCP activities. The claims-based study will examine the rates of receipt of HbA1c testing, eye exams, foot exams, influenza and pneumococcal vaccines, and the prevalence of end stage renal disease (ESRD) among Traditional Medicare beneficiaries with a diabetes diagnosis during calendar year 2002. The rates will be used to establish a baseline to evaluate DPCP activities from 2003-2008. The study will also give MHCC the opportunity to compare current HbA1c and retinal eye exam rates to those found in its study of these rates in CY 1997 to determine what changes have occurred.

As in the 1997 study, the rates of receipt will be evaluated for any significant differences by age, gender, county of residence, and type of health care provider. Additional patient characteristics will be included in this new study: race/ethnicity and (possibly) median income level within the patient's zip code. Evaluation by race/ethnicity will be possible because MHCC is obtaining an enrollee demographic file from the Centers for Medicare & Medicaid Services (CMS) that will include additional demographic information and enable analysts to know if a beneficiary spent any part of the year in a Medicare HMO so that some of the patient's treatment information would be omitted from the traditional Medicare claims.

As a component of their efforts to prevent diabetes and reduce the negative consequences of insufficient patient monitoring and treatment, DPCP intends to form an advisory group that will include representatives from MedChi and the Medicare HMOs operating in Maryland. The study plan will be discussed with the advisory group to maximize the utility of the study results. Due to reductions in MHCC staff, the study will need to be conducted by an outside vendor. Funds for the study come from a \$30,000 grant that was recently awarded to DHMH by CDC expressly for this study, supplemented by funds from MHCC for the analysis and for the purchase of the beneficiary demographic file from CMS. Because the study will use 2002 claims data that will not be available to us until September, we expect the request for proposals to be issued in August.

MOU with University of Maryland School of Pharmacy

Dr. Fadia Shaya, Assistant Director of the Center on Drugs and Public Policy, will head a study of pharmacy claims from the Commission's Medical Care Data Base that will examine the changes in out-of-pocket (OOP) spending for non-elderly Maryland residents with pharmacy coverage from 1999 to 2000 to 2001. The study will look at the trends in OOP per prescription and the annual OOP per user. In addition to exploring changes across all drugs and all users, the study will examine the trends for branded versus generic drugs, newly approved versus pre-existing branded drugs, for chronic use medications, and will compare OOP trends among patients by age group and by gender. The study is currently underway and we expect the results to be presented at the July commission meeting.

HRSA-related Activities

Staff is currently working on a presentation for the Health Care Coverage Workgroup's next meeting on June 5, 2003. The presentation will provide workgroup members with key information about the state's uninsured obtained by analyzing the most Current Population Survey data available, CY2000-2001.

Preliminary studies of the Maryland Health Insurance Coverage Survey data by MHCC staff and the re-weighting vendor have revealed significant limitations in the data. In light of these limitations, staff has decided to make use of alternative data sources in evaluating the duration of lapses in insurance coverage and in determining the relative importance of factors that explain health insurance coverage for different subpopulations within the state. To ensure that the study of lapses serves the needs of policymakers, staff will meet with a group of policymakers and researchers to discuss what information regarding lapses and transitions from one state to another are of interest to them. At this meeting we will also discuss the issue of “actionable” barriers to insurance coverage to discover what information the group would find most useful from the regression analyses to determine which factors are most important in explaining insurance coverage choices by residents.

EDI Promotion and HIPAA Awareness

The EDI/HIPAA Workgroup continued its development efforts on the draft of the “Transactions Standards & Code Sets: A Practice Management Assessment Guide for Medical Offices.” This assessment tool is designed to assist small facilities and practitioners in complying with new claim submission requirements that become effective on October 16, 2003.

The staff continues to provide support to health care organizations in complying with HIPAA. Listed below are some of the organizations that staff supported during April:

- Staff fielded approximately 10 HIPAA telephone inquiries per day. Questions related to privacy, security, and the transaction standards and code sets.
- Presented on HIPAA’s privacy standards to the Southern Maryland Dental Society. In general, dentists have been slow to adopt the privacy standards.
- Convened a HIPAA compliance workshop for EPIC pharmacist in Aberdeen. Approximately 75 pharmacists and pharmacy technicians attended the workshop.
- Developed a HIPAA question and answer session for medical providers affiliated with Atlantic General Hospital for a session scheduled for early May.
- Reviewed privacy at an Anne Arundel County MGMA meeting. Approximately 90 office managers attended the event.
- Worked with the president of the Maryland State Chiropractic Association in setting up a HIPAA workshop for their summer conference.
- Presented on EDI/HIPAA at a Maryland Hospital Association members meeting. Approximately 25 representatives attended the meeting.
- Worked with the Carroll County Health Department in setting up a summer EDI/HIPAA conference for mental health workers in Carroll County. Approximately 75 mental health workers are projected to attend the event.
- Reviewed and provided feedback to approximately 15 medical offices on the correctness of their HIPAA privacy documentation.
- Provided support to the privacy officer at Franklin Square Hospital in developing their summer provider education program. This year, three presenters will overview different aspects of the HIPAA regulations.
- Conducted a regional HIPAA readiness workshop for dental and medical office managers in Hagerstown. Approximately 35 offices’ staff attended the session.
- Presented on EDI/HIPAA at Peninsula Regional Medical Center. Approximately 100 physicians and medical office staff attended the event.
- Worked with the medical director at Holy Cross Hospital to identify speakers to present on HIPAA at their summer physician education program.

- Worked with the executive director of the Maryland Optometrist Association in planning a HIPAA session at their summer conference.
- Provided consultative support to Western Maryland Health Systems in complying with HIPAA's privacy requirements.
- Presented on HIPAA's privacy requirements to the medical staff at Suburban Hospital Center. Approximately 80 physicians and their office staff attended the event.

EHN-Certification

Over the last month, the SSI Group, a large mid-western electronic health network, notified Commission staff that it is interested in obtaining Maryland certification. The SSI Group is considered one of the top five electronic health networks for hospital transactions. They are exploring expanding their services to the physician market. EyeFinity, Inc., a small network based in California, has initiated discussion with MHCC regarding certification under the small business provision of the certification program.

Institutional Review Board

The MHCC Institutional Review Board (IRB) is scheduled to meet on June 4th to review draft documents for creating a minimum data set of the DC hospital database that complies with the HIPAA requirements. The IRB expects to finalize their recommendation in time for the July Commission meeting.

PERFORMANCE & BENEFITS

Benefits and Analysis

Comprehensive Standard Health Benefit Plan (CSHBP)

At the November 2002 meeting, the Commission approved the proposed regulations to implement one change to the CSHBP, previously voted on at the October 2002 meeting: coverage for residential crisis services. The proposed regulations were published in the *Maryland Register* on January 24th. The comment period ended on February 24th. No public comments were received. At the March 2003 meeting, the Commission approved the regulations. This change will be implemented effective July 1, 2003.

On January 31st, Commission staff mailed survey packets to all carriers participating in the small group market in Maryland to collect their annual financial data. The deadline for carriers to submit these data was April 4th. All carriers responded timely. Our consulting actuary is in the process of auditing several carrier submissions. Staff is in the process of analyzing the survey results, including number of lives covered, number of employer groups purchasing the CSHBP, loss ratios, average premiums as they relate to the 12-percent affordability cap, etc. Staff will present these findings at the June Commission meeting. As a result of the passage of SB 477, "Small Business Health Insurance Affordability Act," by the 2003 General Assembly, the Commission also is responsible for evaluating the cost of the CSHBP based on a 10-percent affordability cap.

Another provision in SB 477 requires the Commission, in consultation with the MIA, to perform an analysis and make recommendations on the administrative expenses in the small group market including the amount and distribution of administrative costs, strategies for lowering these costs, and the appropriateness of the medical loss ratios. This report is due by January 1, 2004. In addition, by December 1, 2003, the Commission must prepare a report outlining the methodology

used by the Commission in developing the CSHBP, and the feasibility of creating a “Basic Plan” in addition to the CSHBP.

Commission staff has developed a website to be used as a guide for small business owners in their search for health insurance for their employees. This “Guide to Purchasing Health Insurance for Small Employers” is available on the Commission’s website at: www.mhcc.state.md.us/smgrpmt/index.htm. Commission staff is in the process of developing a bookmark describing information available on the small group website. This bookmark will be presented to the Commission in the summer.

Evaluation of Mandated Health Insurance Services

At the November meeting, Mercer presented its evaluation of mandated health insurance services as to their fiscal, medical and social impact, along with all proposed mandates that failed during the 2002 General Assembly session to the Commission for release for public comment. At the December meeting, the Commission approved the report for release to the legislature, after some modifications to the Executive Summary. The final report was sent to the General Assembly in January 2003, and is available on the Commission’s website at: www.mhcc.state.md.us/cshbp/mandates/finalmercerreport02.pdf.

The 2003 General Assembly passed HB 605, “Evaluation of Mandated Health Insurance Services.” As a result, § 15-1502 of the Insurance Article was repealed; therefore, the Commission is no longer responsible for conducting a full review of each existing mandate if the 2.2-percent affordability cap is reached. However, § 15-1501 remains in effect, which requires the Commission to assess the fiscal, medical, and social impact of any mandates proposed by the 2003 General Assembly. Additionally, HB 605 requires the Commission to evaluate all existing mandates every four years, in terms of the following: (1) an assessment of the full cost of each existing mandate as a percentage of Maryland’s average annual wage, as a percentage of individual premiums, and as a percentage of group premiums; (2) an assessment of the degree to which an existing mandate is covered by self-insured plans; and (3) a comparison of Maryland mandates to those provided in Delaware, the District of Columbia, Pennsylvania, and Virginia based on number of mandates, type of mandate, the level and extent of coverage for each mandate, and the financial impact of differences in level of coverage for each mandate. The first of these reports is due to the legislature January 1, 2004.

Maryland Health Insurance Plan (MHIP)

In 2002, the General Assembly enacted and the Governor signed HB 1228 under which the SAAC program and the Short-Term Prescription Drug Subsidy Program will be replaced with the Maryland Health Insurance Plan Fund and Senior Prescription Drug Program. Both will be administered by the newly created Maryland Health Insurance Plan (MHIP), an independent agency within the MIA. The Executive Director of the MHCC is a member of the Board. The MHIP Fund is financed through a proportionate assessment on hospital net patient revenue that would equal the CY 2002 SAAC funding. The new program is required to be operational on July 1, 2003, and hospitals began paying the assessment as of April 1, 2003 in order to fund the start-up. The MHIP Board is responsible for running the programs.

The MHIP Board has selected Maryland Physicians Care (MPC) as the MHIP contract administrator. As contract administrator, MPC will review applications from potential members, collect premiums, and pay health insurance claims for MHIP. MPC is owned by four Maryland community health systems: Maryland General Health Systems in Baltimore, Washington County Health System in Hagerstown, Western Maryland Health System in Cumberland, and St. Agnes HealthCare in Baltimore.

Carriers must report to the MIA the number of applications for medically underwritten individual policies that they have declined. The Senior Prescription Drug Program is funded through enrollee premiums and a subsidy by a nonprofit health service plan (CareFirst) not to exceed its premium tax exemption. The MHCC is no longer responsible for developing the benefit plan. The MIA required CareFirst (Maryland and D.C.) to have the last SAAC open enrollment in December 2002. CareFirst complied by advertising the open enrollment period in local newspapers throughout the month of December 2002.

The 2003 General Assembly passed HB 1100, allowing Bethlehem Steel retirees between the ages of 55 and 64 who do not yet qualify for Medicare to be able to enroll in MHIP beginning July 1st.

Legislative and Special Projects

Uninsured Project

DHMH, in collaboration with MHCC and the Johns Hopkins School of Public Health, was recently awarded a \$1.2 million State Planning Grant by the Health Resources and Services Administration (HRSA). HRSA is the federal agency that oversees programs to ensure access to care and improve quality of care for vulnerable populations. The one-year federal grant provides Maryland with substantial resources to examine the State's uninsured population and employer-based insurance market and to develop new models to make comprehensive health insurance coverage fully accessible to all Maryland residents.

Among the several activities, the one year grant will enable DHMH and MHCC to conduct further analysis of existing quantitative data sources (Maryland Health Insurance Coverage Survey, MEPS-IC, and CPS), as well as collect additional data that will help us design more effective expansion options for specific target groups. In addition, we have conducted focus groups with employers in order to better understand the characteristics of firms not currently participating in the state's small group market. For those firms currently participating in the CSHBP, issues were probed relating to costs of coverage and knowledge of the base CSHBP. In an effort to increase the take-up rate in the small group market, marketing materials were presented to the focus groups for review and modification. Shugoll Research was selected as the vendor to conduct these focus groups. The focus groups were completed on Friday, February 14, 2003, with over 70 employers and 20 brokers participating. A report summarizing the findings from the focus groups will be made available in May.

A third meeting with the Health Care Coverage Workgroup was held on April 11, 2003. This group, appointed by the former Deputy Secretary for Health Care Financing, is comprised of members who represent the provider, business, health care advocacy, and health care research communities in the state. During the March meeting, members were asked to score each of the 20 options presented according to their individual interest in the option. In April, the results of the options scoring survey were presented to the group, along with the procedure for further narrowing the options. The next meeting with the Workgroup will be held on June 5th in College Park.

The grant team requested a one-year, no cost extension of the project timeline, with an interim report due to the Secretary of the Department of Health and Human Services in June 2003 and the final report submitted in December 2003. The final report must outline an action plan to continue improving access to insurance coverage in Maryland.

Patient Safety

Chapter 318 (HB 1274) of 2001 requires the Commission, in consultation with DHMH, to study the feasibility of developing a system for reducing preventable adverse medical events. A Maryland Patient Safety Coalition was initiated by the Delmarva Foundation and served as the Commission's sounding board for its activities related to patient safety. Three workgroups were formed: one to look at issues related to systems changes to be recommended; one to address current regulatory oversight and reporting requirements; and a third to discuss issues related to a proposed Patient Safety Center.

A preliminary report, approved by the Commission at the December 2001 meeting, was sent to the General Assembly. One of the preliminary recommendations has been enacted by the General Assembly and signed by the Governor. That bill removes the medical review committee statute that applies to all health care practitioners from the BPQA statute, where it is currently codified, and places it in a separate subtitle within the Health Occupations Article to make practitioners more aware of the protections available to them. It also codifies case law to clarify that certain good faith communications designed to lead to remedial action are protected even when they are not made directly to a medical review committee or committee member, but are nevertheless designed to remedy a problem under the jurisdiction of a medical review committee. The final report has been approved by the members of the Commission and was submitted to the members of the Maryland General Assembly in January. Commission staff briefed two Legislative Committees - the House Health and Government Operations Committee and the Senate Education, Health, and Environmental Affairs Committee – on the study. A bill was introduced in the House to grant medical review committee status to the Maryland Patient Safety Center, as designated by the Commission. This bill will grant protections against legal liability and disclosure of information. It passed out of both Houses and was signed into law by the Governor.

The Maryland Patient Safety Steering Committee met in April to discuss the formulation of mission and vision statements for the Coalition, and the roles of other state coalitions. It is anticipated that the Maryland Patient Safety Coalition will meet sometime during the summer.

In addition, Commission staff, along with the University of Maryland Office of Research and Development, LogiQ (a non-profit research entity affiliated with the Maryland Hospital Association) and the Delmarva Foundation recently submitted a proposal for a federal grant that would fund the creation of a Patient Safety Center. The grant proposal was submitted October 1, 2002.

Facility Quality and Performance

Nursing Home Report Card

Chapter 382 (SB 740) of 1999 requires the Commission, in consultation with the Department of Health and Mental Hygiene and the Department of Aging, to develop a system to comparatively evaluate the quality of care and performance of nursing facilities. The web-based Nursing Home Performance Evaluation Guide is available through the Commission's website. The Guide includes a Deficiency Information page, data from the Minimum Data Set (MDS) and the MHCC Long Term Survey, as well as an advanced search capability, allowing consumers to search by facility characteristics and certain services.

The Commission participated in the Centers for Medicare and Medicaid Services (CMS) pilot program with five other states from April through early November 2002. At the conclusion of the pilot, CMS conducted a national rollout of the CMS Nursing Home Quality Initiative on

November 12, 2002. The Commission's website was subsequently updated in January 2003 to reflect the final CMS Nursing Home Quality measures. The website was also updated to include quality indicator data from January through June 2002. Seven of the 10 quality measures reported on the CMS website are featured on the Maryland Guide in the same format as the current Quality Indicators are, utilizing the symbols that separate the top 20%, bottom 10% and all others. CMS is reporting two new measures and one revised measure that are risk-adjusted using a Facility Adjustment Profile (FAP). Two of these measures are currently featured on the Guide without the FAP (Prevalence of Stage 1-4 pressure ulcers for chronic care and Failure to improve/manage delirium for post acute care) as recommended by the Hospital Report Card Steering Committee.

During March 2003, all facility deficiency information was updated reflecting survey information from the Office of Health Care Quality through December 2002. Consumers can also obtain historical information on nursing home deficiencies since January 2001.

Hospital Report Card

Chapter 657 (HB 705) of 1999 requires the Commission to develop a similar performance report on hospitals. The required progress report has been forwarded to the General Assembly. The Commission has contracted with the Delmarva Foundation, in partnership with Abt Associates, to: (1) analyze hospital data to develop appropriate indicators for inclusion in the Hospital Performance Evaluation Guide, and (2) design and execute a consumer-oriented website for the Guide. The initial version of the Hospital Performance Evaluation Guide was unveiled on January 31, 2002.

A new edition of the Hospital Guide will be released during a press conference scheduled for May 16, 2003 at 1:00 p.m. and will include quality of care information specific to the treatment and prevention of congestive heart failure and community acquired pneumonia. For the past year, all Maryland hospitals have participated in this data collection and analysis project in preparation for this public release. The first sets of conditions were selected from the Joint Commission on Accreditation of Healthcare Organization's (JCAHO's) ORYX initiative, which collects quality of care information from hospitals in a method designed to permit rigorous comparisons using standardized evidence-based measures.

The new edition of the Guide will contain information on individual hospital rates, the state average, and the highest rate achieved by a hospital for each of the individual measures. Consumers will be provided with detailed information on why the data is important and what can be done when there is a question about the care that was received. A statewide hospital meeting will be held on May 9, 2003, prior to the release of the Guide, to provide hospitals with a final review of the individual hospital measures and to answer any remaining questions.

The Hospital Guide continues to feature structural (descriptive) information and the frequency, risk-adjusted length-of-stay, and risk-adjusted readmissions rates for 33 high volume hospital procedures. Data for those facilities with less than 20 discharges per DRG in the reporting period are not presented.

DRG data was updated in December 2002 to include admissions occurring between December 1, 2000 and November 30, 2001. Three DRGs that were featured previously are not included due to the small number of hospitals that had 20 or more discharges per DRG. Readmission rates for circulatory system diseases and disorders are featured. The formula used to calculate the

readmission rates for all DRGs was altered to better define transfers to other hospitals and excludes “planned” readmissions.

Future plans for the Guide include the addition of other quality measures, patient satisfaction information, and patient safety information.

The Delmarva Foundation was awarded the ‘lead state’ to head a three-state hospital public reporting pilot project initiated by CMS. Delmarva will assist CMS with the following:

- Test the collection and reporting of the JCAHO/CMS performance measure sets;
- Test the AHRQ sponsored standardized patient experience (satisfaction) survey;
- Test additional performance measures as determined by the pilot states;
- Determine the least burdensome ways for hospitals to meet upcoming public reporting requirements;
- Determine how to integrate CMS mandated reporting with existing state level public reporting activities; and
- Determine how to best involve stakeholders in the development and execution of hospital public reporting activities.

The Hospital Report Card Steering Committee serves as the steering committee for the pilot and has been expanded to include additional rural, minority, payer, and business/employer representatives. The Committee will be the primary vehicle for obtaining input and consensus prior to initiating the state specific activities. The steering committee will also be tasked with providing feedback to CMS on the pilot and identifying barriers to successful implementation. Hospitals from the three pilot states will take part in a pilot satisfaction survey during the summer of 2003. Information from this survey will be confidential. The Agency for Health Care Research and Quality (AHRQ) selected hospitals in each state in February 2003. The survey will be administered through the mail with follow-up contact made by telephone. In order to obtain a representative sample of hospitals in the pilot satisfaction study, the Commission staff is requiring that each acute care hospital participate in the pilot. This will also satisfy the legislative requirement that the Commission collect satisfaction data.

In addition to the Pilot Project, a national coalition of healthcare organizations, including the American Hospital Association (AHA), the American Association of Medical Colleges (AAMC), the Federation of American Hospitals (FAH), the National Quality Forum (NQF) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), announced a voluntary initiative that will encourage every hospital in the country to collect and publicly report quality information.

The “starter set” of measures will draw from three of JCAHO’s Core Measure Sets: Acute Myocardial Infarction (AMI), Congestive Heart Failure (CHF) and Community-Acquired Pneumonia (CAP). Initially, Maryland hospitals will be able to report measures from just two of the areas (the CHF and CAP measures that are already being collected), but will be strongly encouraged to report from all three as soon as possible. This information, in addition to being on the MHCC website as currently in process, will also be on CMS’s website (www.medicare.gov) sometime this summer.

Ambulatory Surgery Facility Report Card

Chapter 657 (HB 705) of 1999 also requires the Commission to develop a performance report for Ambulatory Surgery Facilities (ASFs). The Commission has developed a web-based report that will be released on May 16, 2003. The website will contain structural (descriptive) facility

information including the jurisdiction, accreditation status, and the number and type of procedures performed in the past year. The site will also include several consumer resources.

An ASF Steering Committee was convened to guide the development of the report and will consist of representatives from a multi-specialty facility, a large single specialty facility, an office based facility, a hospital based facility, and a consumer representative. An exploratory meeting was held with a subset of this group in January 2003. Subsequently, the Steering Committee provided input on several of the proposed web pages including a consumer checklist, glossary, and list of resources.

HMO Quality and Performance

Distribution of 2002 HMO Publications

| Cumulative distribution: Publications released 9/23/02 | 9/23/02- 4/30/03 | |
|---|-------------------------|---|
| | Paper | Electronic Web |
| <i>The 2002 Consumer Guide to Maryland HMOs & POS Plans (25,000 printed)</i> | 21,613 | Interactive version 1,145 visitor sessions |

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| <i>2002 Comprehensive Performance Report: Commercial HMOs & Their POS Plans in Maryland (700 printed)</i> | 608 |
|--|-----|

2003 Policy Report (2002 Report Series) – Released January 2003; distribution continues until January 2004

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|---|-----|
| <i>Policy Report on Maryland Commercial HMOs & POS Plans (1,200 printed)</i> | 731 |
|---|-----|

Reporting monthly statistics on the frequency of requests for electronic versions of HMO performance reports has been suspended for this report series. Analysis of logs containing detailed coding information began last fall when the new report series became available and an unusual surge in *Comprehensive Report* downloads emerged. HMO Division staff has received needed assistance from the Data Systems and Analysis staff, during this period, in identifying several causes for the miscounts. To compensate for these factors, staff will continue working to define parameters to improve measurement of electronic reports.

Alternatively, web users may select the interactive version of the *Guide*, which is hosted by Glows in the Dark. Activity has remained stable for the 2002 report and comparatively similar to prior year levels.

New letters were drafted and sent out county associations and businesses known to have spring open enrollment advising of the *Guide's* availability. Several business and numerous consumers received the *Guide* in April.

2003 Performance Reporting: CAHPS Survey and HEDIS Audit

The final phase of the HEDIS audit is nearing completion. Auditors completed site visits to all plans. Review of source used for measure calculation and validation of medical record review is nearly complete.

At MHCC's request, the audit contractor, HealthcareData.com (HDC), provided an assessment of each plan's audit that included a mid-term summary of outstanding issues and an early assessment of each plan's available measure calculations. The interim assessment of HEDIS rates was based on computations of expected values for each plan's eligible population in each of the measures using a benchmarking tool developed by HDC. Preliminarily four plans have measures at risk for receiving "not report" designations. Lead auditors are working diligently with plans, and their vendors in several cases, to resolve data issues. Regarding use of the benchmarking tool provided to each plan, HDC found reasonable use of the tool by plans. Use of this tool will be highlighted during the December kick-off meeting because of the focus it brings to the process and the importance of doing an early identification and assessment of the eligible populations.

HMO Division staff will provide HDC with comments and recommendations based on the in-depth examination of all phases of the 2003 audit. This task will be completed next month.

The final telephone phase of the CAHPS survey of plan members ended at the close of April. Telephone attempts were increased from six to ten as a remedial action for the loss any potential respondents lost due to a minor error by the vendor. Final rates of response won't be available until the end of May, after data have been cleaned. However, the early indication is that the overall response rate has decreased by several percentage points. Staff is preparing detailed instructions for Synovate, our survey contractor, on content and organization of the reports of CAHPS results that will be sent this summer to each plan, NCQA, the federal Office of Personnel Management (for plans that provide health care to federal employees), and to MHCC. Final CAHPS results will remain a part of the 2003 series of publications.

For several years MHCC has sponsored the National CAHPS Benchmarking Database (NCBD) by asking Maryland plans to voluntarily allow submission of their survey results to this organization. Though NCBD case-mix adjusts the survey results, strong similarities exist between this approach and NCQA's unadjusted results. Continued participation will be based largely on supporting the existence of a database for researchers rather the expectation that data will become an information source for HMO reports.

Report Development Contract/Optional Unit Work

HMO Quality and Performance Division staff completed the majority of tasks necessary to conduct focus group testing. The objective of the focus groups is to test the content and design of the *Guide*, as well as to learn consumer and employer preferences for learning about the availability of this report. Moderator scripts were written and revised, facilities scheduled, and recruiting mostly completed in April. Family Research Group will moderate the two consumer groups and two employer groups scheduled to meet on May 12 and 13.

Report development has a head start this year. Planning typically does not begin until June. However, with all aspects of the *Guide* under review, a compilation of alternative data and design features were assembled for consideration by staff and focus group participants.

Other Activities

HMO Division staff attended the monthly health officers round table and participated in DHMH's Risk-Adjusted Profiling Project Advisory Committee.

HEALTH RESOURCES

Certificate of Need

During April 2003, staff issued on the Commission's behalf a total of 13 determinations of coverage by Certificate of Need review. These included two acquisitions of existing health care facilities. The Commission received notice of the intended transfer of ownership of the Berlin Nursing and Rehabilitation Center in Worcester County to Mid-Atlantic Long Term Care, LLC and Berlin Properties, LLP. Also during April, Bayada Nurses, Inc. of New Jersey received a determination of non-coverage for its acquisition of Diversified Health Services, Inc., a home health agency affiliated with the Greater Baltimore Medical Center.

Staff issued three determinations of non-coverage related to hospital capital projects during this period. One letter confirmed that a previously-approved project by Garrett County Memorial Hospital does not require Certificate of Need review despite some significant additions to its scope and its cost, because the hospital has confirmed its previous commitment not to seek a rate increase related to the project beyond the statutory limit. The capital costs associated with the project have increased from \$4.66 million to \$8.74 million, and, in addition to the emergency department, same-day surgery, and admissions departments, now involves renovations to radiology, laboratory and laundry areas of the facility. Suburban Hospital in Bethesda received non-coverage determinations related to two unrelated renovation projects at the hospital, each of which has patient care-related costs under the new \$1.55 million capital threshold. One project will re-develop an area within the ED for pediatric emergencies, and also create a contiguous 4-bed pediatric inpatient unit. The other project will renovate an oncology unit at Suburban Hospital.

One capital expenditure proposed by a nursing home also received a non-coverage determination during April: the \$1.4 million cost of an assisted living pavilion on the campus of Waldorf Health Care Center in Charles County. This project was the subject of a coverage determination not as an assisted living facility, which do not require CON review, but as a capital expenditure "by or on behalf of a health care facility" that the Commission does regulate, at the nursing home itself.

Three determinations involved changes in licensed bed capacity. Two of the three authorized temporary delicensures at nursing facilities (one in Baltimore City, and the other in Caroline County) were recently acquired by other companies. In the third licensure-related determination, the Commission notified Extencicare, a Wisconsin corporation, that the Commission considers Extencicare's authority to operate 132 nursing home beds at Greenbelt Nursing and Rehabilitation Center in Prince George's County abandoned. Although the Commission had received notice in 2001 of a proposed acquisition and subsequent re-development of the facility, the acquisition was never completed, and the beds had been out of service since January 1999.

During March, staff also issued determinations of non-coverage for single non-sterile procedure rooms to be established in an endoscopy center in Baltimore County and a physician office setting in Charles County. Also related to ambulatory surgery, staff issued non-coverage

determinations in response to notice of changes in physician owners in one existing office-based surgery center, and a notice that a HealthSouth-owned center in southwest Baltimore City would close permanently. Howard County General Hospital received a determination that CON review was not required for the re-regulation by the Health Services Cost Review Commission (HSCRC) of rates charged for surgeries and ancillary services provided at The Center for Ambulatory Services, a building on its campus in which HSCRC had de-regulated rates in 1994.

Acute and Ambulatory Care Services

Staff is developing revisions to the Bed Designation Form that is used by the Commission and the Office of Health Care Quality to implement Maryland's annual acute care bed licensure law, Health-General §19-307.2, and to serve as the single, official source of hospital bed inventory. A new item has been added to indicate the number of beds that can actually be set up and made available for patient care (independent of either current utilization or staffing issues). Two supplemental surveys will be included: one on obstetrics services capacity, to include use of alternatives to traditional hospital obstetrics services, such as LDRP rooms; and, the other on emergency services treatment capacity. The proposed forms are available on the Commission's website for comment. The new bed licensure data will be sent to all hospitals using this revised form on or about June 3, 2003 for fiscal year 2004. The final licensed bed inventory forms will be sent out in late June and will be effective July 1, 2003.

Staff has established the Acute Care Hospital Planning Workgroup to discuss issues raised concerning the proposed revisions to the State Health Plan (SHP) chapter on acute inpatient services, COMAR 10.24.10. A preliminary draft of the proposed SHP changes, including proposed revisions to the acute care bed need projection methodology, were both released for informal public comment in 2002. The third workgroup meeting was held on April 10, 2003. The agenda included a discussion of proposed changes to the draft Plan's project review standards in response to written public comments. The agenda also included a discussion of the second survey of daily fluctuations in hospital acute care census, conducted over a week in March of 2003. The next meeting of the workgroup is scheduled to be held on May 30, 2003.

Long Term Care and Mental Health Services

Staff worked on the final compilation, analysis, and production of the *2001 Report on Maryland Nursing Home Occupancy Rates and Nursing Home Utilization by Payment Source*. This report summarizes data on the occupancy levels and utilization of licensed comprehensive care facilities and extended care facilities in Maryland during FY 2001. After an introductory section, Part II describes statewide and regional nursing home occupancy and utilization patterns for FY 2001. In Part III, facility-specific nursing home occupancy and utilization for FY 2001 is presented. Part IV provides a summary and analysis of trends in regional and statewide occupancy, while Part V provides a summary of trends in regional and statewide utilization rates by payment source. Finally, Part VI (technical notes section) describes details of current capacity, and changes in licensed capacity that occurred during FY 2001. Facilities with temporarily restricted beds and other restricted beds are also described in the final section. This report will be presented to the Commission at the May 16th meeting.

Another area of interest in the Long Term Care Unit is post-acute care. Staff have been working on an analysis of data, collected by the Commission in its Maryland Subacute Care Survey, on care provided in both chronic hospitals and acute hospital-based skilled nursing facilities. In this effort, staff are also coordinating with efforts of the HSCRC as they develop a methodology for reimbursement for chronic hospitals. The HSCRC has also begun to collect case mix data on the

private chronic hospitals in order to be able to do a more detailed analysis of utilization and cost in this area, and to set chronic rates in a more consistent manner.

A conference call was held on April 28th with Myers and Stauffer, the consultant conducting analysis of Maryland's MDS data. Topics addressed included analysis of current residents and admissions, assignment of zip codes, and identification of variables for diversion of residents from nursing homes. On April 30th, staff attended the monthly meeting of the Medicaid Nursing Home Liaison group. This group meets to discuss Medicaid policies and regulations and their impact on the nursing home industry. The focus of the April meeting was impending budget cuts in Medicaid and the impact on rate setting.

Specialized Health Care Services

On Friday, April 18, 2003, Commission staff met with representatives of autologous stem cell transplant programs in the Maryland and Washington regions to discuss major issues related to utilization. At the public meeting of the Commission on May 16th, Commission staff will present a Statistical Brief on Organ Transplant Services and the Projected Utilization and Need for New Organ Transplant Programs for Target Year 2005.

At the meeting on May 16th, Commission staff will present a briefing on the Recommendations from the Interventional Cardiology Subcommittee of the Advisory Committee on Outcome Assessment in Cardiovascular Care. The next meeting of the Inter-Hospital Transport Subcommittee of the Advisory Committee on Outcome Assessment in Cardiovascular Care will be held on May 28th at 6:00 p.m. at 4160 Patterson Avenue, Baltimore, Maryland. The Steering Committee is expected to meet in June.

On May 15th, facilities licensed as special rehabilitation hospitals in Maryland will submit discharge data for the first quarter of 2003. Commission staff has provided technical assistance to the facilities regarding the submission of two new data elements in the Uniform Hospital Discharge Abstract Data Set.